SERFF Tracking Number:	*FRTH-128184470*	*State:*	*Arkansas*
Filing Company:	*Forethought Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*LTC3001-02*		
TOI:	*A02I Individual Annuities- Deferred Non-Variable*	*Sub-TOI:*	*A02I.003 Single Premium*
Product Name:	*Single Premium Deferred Annuity Application*		
Project Name/Number:	*Single Premium Deferred Annuity Application/LTC3001-02, LTC3002-02*		

Filing at a Glance

Company: Forethought Life Insurance Company

Product Name: Single Premium Deferred Annuity Application	SERFF Tr Num: FRTH-128184470	State: Arkansas
TOI: A02I Individual Annuities- Deferred Non-Variable	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: A02I.003 Single Premium	Co Tr Num: LTC3001-02	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Kasey Poettker	Disposition Date: 04/16/2012
	Date Submitted: 04/11/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name: Single Premium Deferred Annuity Application	Status of Filing in Domicile: Pending
Project Number: LTC3001-02, LTC3002-02	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 04/16/2012
	State Status Changed: 04/16/2012
Deemer Date:	Created By: Kasey Poettker
Submitted By: Kasey Poettker	Corresponding Filing Tracking Number:

Filing Description:

Please find attached forms LTC3001-02 and LTC3002-02 for your review. These forms are new and do not replace any form currently on file with your department.

Both of these forms are very similar to LTC3001-01 and LTC3002-01 which were approved by your office on 10/20/11, Serff tracking #FRTH-127727194. A few revisions have been made to these forms for ease of use by the consumer. Attached are red-line versions of these forms showing the revisions.

The forms are being filed on a general use basis and will be marketed in the individual annuity market exclusively by the

Company's licensed agents/brokers and bank distribution channels. The forms contain no unusual or controversial features or language that deviate from normal insurance industry standards.

Sincerely,

Kasey Poettker
Sr. Compliance Analyst
Forethought Life Insurance Company
State Narrative:

Company and Contact

Filing Contact Information

Kasey Poettker, Compliance Analyst	kasey_poettker@forethought.com
1 Forethought Center	812-933-6748 [Phone]
Batesville, IN 47006	812-933-6348 [FAX]

Filing Company Information

Forethought Life Insurance Company	CoCode: 91642	State of Domicile: Indiana
1 Forethought Center	Group Code: 1266	Company Type: Insurance
Batesville, IN 47006	Group Name:	State ID Number:
(800) 648-0075 ext. [Phone]	FEIN Number: 06-1016329	

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	$50.00 per form - 2 forms
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Forethought Life Insurance Company	$100.00	04/11/2012	57884138

SERFF Tracking Number:	*FRTH-128184470*	*State:*	*Arkansas*
Filing Company:	*Forethought Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*LTC3001-02*		
TOI:	*A02I Individual Annuities- Deferred Non-Variable*	*Sub-TOI:*	*A02I.003 Single Premium*
Product Name:	*Single Premium Deferred Annuity Application*		
Project Name/Number:	*Single Premium Deferred Annuity Application/LTC3001-02, LTC3002-02*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/16/2012	04/16/2012

SERFF Tracking Number:	*FRTH-128184470*	*State:*	*Arkansas*
Filing Company:	*Forethought Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*LTC3001-02*		
TOI:	*A02I Individual Annuities- Deferred Non-Variable*	*Sub-TOI:*	*A02I.003 Single Premium*
Product Name:	*Single Premium Deferred Annuity Application*		
Project Name/Number:	*Single Premium Deferred Annuity Application/LTC3001-02, LTC3002-02*		

Disposition

Disposition Date: 04/16/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FRTH-128184470*	*State:*	*Arkansas*
Filing Company:	*Forethought Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*LTC3001-02*		
TOI:	*A02I Individual Annuities- Deferred Non-Variable*	*Sub-TOI:*	*A02I.003 Single Premium*
Product Name:	*Single Premium Deferred Annuity Application*		
Project Name/Number:	*Single Premium Deferred Annuity Application/LTC3001-02, LTC3002-02*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Red-Line Versions - LTC3001 & LTC3002		Yes
Form	FORECARE ANNUITY APPLICATION		Yes
Form	FORECARE ANNUITY APPLICATION - MEDICAL QUESTIONNAIRE		Yes

SERFF Tracking Number:	*FRTH-128184470*	*State:*	*Arkansas*
Filing Company:	*Forethought Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*LTC3001-02*		
TOI:	*A02I Individual Annuities- Deferred Non-Variable*	*Sub-TOI:*	*A02I.003 Single Premium*
Product Name:	*Single Premium Deferred Annuity Application*		
Project Name/Number:	*Single Premium Deferred Annuity Application/LTC3001-02, LTC3002-02*		

Form Schedule

Lead Form Number: LTC3001-02

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LTC3001-02	Application/ Enrollment Form	FORECARE ANNUITY APPLICATION	Initial		52.000	LTC3001-02 Fore Care Application 03.08.12 subm.pdf
	LTC3002-02	Application/ Enrollment Form	FORECARE ANNUITY APPLICATION - MEDICAL QUESTIONNAIRE	Initial		53.000	LTC3002-02 Medical Ques 03_06_12 subm.pdf

Forethought Life Insurance Company
One Forethought Center
P.O. Box 246
Batesville, IN 47006-0246
(855) 244-4441
Fax (855) 596-5404

ForeCare[sm] Annuity Application

☑ 9 Year

OWNER (All Policyholder correspondence will be sent to this address.)
Name: _____ Sex: ___ Age: ___ DOB: _____
Address: _____ SSN: _____
Mailing: _____ Daytime Phone: _____

JOINT OWNER (Optional)
Name: _____ Sex: ___ Age: ___ DOB: _____
Address: _____ SSN: _____
Mailing: _____ Daytime Phone: _____

ANNUITANT (Complete only if the Owner and Annuitant are different)
Name: _____ Sex: ____ Age: ___ SSN: _____
Address: _____ Daytime Phone_____ DOB: _____
_____ Relationship to Owner: _____

JOINT ANNUITANT
Name: _____ Sex: ____ Age: ___ SSN: _____
Address: _____ Daytime Phone_____ DOB: _____
_____ Relationship to Owner: _____

PROPOSED INSURED INFORMATION (Must be Owner or Spouse, unless Trust, then must be Annuitant or Spouse)
Name: _____ Sex: ____ Age: ___ SSN: _____
Address: _____ Daytime Phone_____ DOB: _____
_____ Relationship to Owner: _____

PROPOSED JOINT INSURED INFORMATION (Optional, must be Spouse of Insured)
Name: _____ Sex: ____ Age: ___ SSN: _____
Address: _____ Daytime Phone_____ DOB: _____
_____ Relationship to Owner: _____

BENEFICIARY INFORMATION
Primary Beneficiary Name: _____Relationship: _____SSN: _____%_____

Contingent Beneficiary Name: _____Relationship: _____SSN: _____%_____

COUPLES DISCOUNT
Does the Proposed Insured's spouse have long term care benefits inforce or applied for with Forethought Life Insurance Company?
❑ Yes ❑ No If "yes," enter spouse information:

_____	_____	_____	_____
Spouse's Name	Date of Birth	Policy/Contract #	Social Security Number

ANNUITY DEPOSIT
❑ Annuity Deposit …… $_____ **Type of Annuity:** ☑ **Non-Qualified**
❑ Estimated Annuity Deposit of 1035 Exchange/Transfer $_____ **Guaranteed Rate Period**: ❑ 1 Year

Free Withdrawal Option
☑ **10% Free Withdrawal** ☑ **Market Value Adjustment**

RIDER BENEFIT INFORMATION
Rider Selections: ☒ **Rider for Long-Term Care Benefits**
Optional Inflation Protection Benefit Rider (select one)
❑ I reject the 5% compounding Inflation Protection Benefit Rider
❑ I choose the 5% compounding Inflation Protection Benefit Rider

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RIDER BENEFIT INFORMATION CONTINUED

Optional Nonforfeiture Rider (select one)

❑ No I reject the Nonforfeiture Benefit Rider

❑ Yes I accept the Nonforfeiture Benefit Rider

PROTECTION AGAINST UNINTENTIONAL TERMINATION OR REDUCTION OF LONG-TERM CARE BENEFITS

This section is to be completed by the Owner. You have the right to designate a Third Party to receive notice from us of a request from you that results in reduction or termination of the Long Term Care Benefit.

I understand that I have the right to designate others to receive notice from the Company of a request from me that results in the reduction or termination of long-term care benefits.

❑ I elect **NOT** to designate another person to receive such notice.

❑ I designate the following person or entity to receive such notice.

Full Name: _____

Address: _____

City, State, Zip: _____

Telephone Number: _____

OTHER COVERAGE AND REPLACEMENT INFORMATION

The Producer shall comply with any additional state and/or company replacement requirements.

1. Does the proposed Insured currently have a long-term care policy or certificate in force (including health care service contracts or health maintenance organization contracts)? ❑ Yes ❑ No
   If "yes," provide details on Addendum.
2. Has the proposed Insured had a long-term care policy or certificate in force during the last 12 months? ❑ Yes ❑ No
   If "yes," provide details on Addendum.
3. Does the proposed Insured intend to replace any long-term care, medical or health insurance coverage with this coverage? I**f "yes," provide details on Addendum.** ❑ Yes ❑ No
4. Producer must list all health insurance, including long-term care policies that he or she sold to the proposed Insured which are still in force; or were purchased in the last five years but are no longer in force. If "None," check the 'None' box. ❑ None
   Provide details on Addendum.
5. Is the proposed Insured currently eligible for benefits under or covered by Medicaid (not Medicare)? ❑ Yes ❑ No

SIGNATURES Checks must be made payable to: ***Forethought Life Insurance Company***

Do you have any existing life insurance policies or annuity contracts? ❑Yes ❑ No

Will this annuity replace, discontinue or change any existing life insurance or annuity contract issued by a company? ❑Yes ❑ No

I understand this annuity is not federally insured. I have read and understand the important disclosures located in this application. I represent that all statements and answers in this application are complete and true, on my behalf and any person who may claim any interest under this policy.

X _____ X _____

Owner's Signature | Joint Owner's Signature (if applicable)

X _____ X _____

Annuitant's Signature (if not the Owner) | Joint Annuitant's Signature (if applicable)

X_____ X _____

Insured's Signature (if not the Owner or Annuitant) | Joint Insured's Signature (if applicable)

Signed at (state): _____on (date): _____

AGENT INFORMATION

To the best of my knowledge, the applicant has an existing life insurance policy or annuity contract.

❑Yes ❑ No

Do you have any reason to believe this annuity will replace, discontinue or change any existing life insurance or annuity?

❑Yes ❑ No

As agent, have you complied with all State Replacement Regulations and completed all required State Replacement forms?

❑Yes ❑ No

Did you observe the proposed Insured having any physical or mental impairment with regard to walking or talking?

❑Yes ❑ No

If **yes**, attach documentation.

By signing this form, I certify that I have truly and accurately recorded herein the information provided by the applicant.

_____	_____
Licensed Agent's Signature	Business Name and Branch Number
_____	_____
Licensed Agent (Print Name)	State License Number or Agent Number

STATE REQUIRED NOTICES

AR, HI, KY, MA, ND, OK, PA, SD, TN, and WA Residents

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, submits an application for insurance containing any materially false, incomplete, or misleading information, or conceals for the purpose of misleading, any material fact, is guilty of insurance fraud, which is a crime and in certain states, a felony. Penalties may include imprisonment, fine, denial of benefits, or civil damages.

CA Residents – Reg. 789.8

The sale or liquidation of any asset in order to buy insurance, either life insurance or an annuity contract, may have tax consequences. Terminating any life insurance policy or annuity contract may have early withdrawal penalties or other costs or penalties, as well as tax consequences. You may wish to consult independent legal or financial advice before the sale or liquidation of any asset and before the purchase of any life insurance or annuity contract.

CO Residents

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of any insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Department of Regulatory Agencies.

ME Residents

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MD, NM and RI Residents

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NJ Residents

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

VA Residents

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Forethought Life Insurance Company
One Forethought Center
P.O. Box 246
Batesville, IN 47006-0246
1-855-244-4441

FORE THOUGHT®

Forethought Annuity Application – Medical Questionnaire

To begin interview, fax this completed form and signed HIPAA to 855-206-8731 and call 877-272-0578.

Proposed Insured

Name (First, Middle Initial, Last)		Date of Birth (mm/dd/yyyy)	
Mailing Address		Height	Weight
City	State	Social Security Number	

Proposed Insured Health Questions (any questions 1-6 answered 'Yes' will be an automatic decline)

1. Are you currently confined to a nursing facility, receiving home health care, using Adult Day Care services, receiving hospice care, residing in an Assisted Living Facility, or in the last 12 months have you used or been medically advised to seek such confinement or care, or are you currently hospitalized or confined to a bed? ❒ Yes ❒ No

2. Do you require assistance or supervision in performing any of the following activities: taking medications, bathing, dressing, transferring, eating, toileting, bowel or bladder control or mobility? ❒ Yes ❒ No

3. Do you use or have you been medically advised to use a walker, multi-prong cane, wheelchair, motorized scooter, hospital bed, stair lift, or any medical appliance such as oxygen, respirator, dialysis machine or have a defibrillator implanted? ❒ Yes ❒ No

4. Have you been medically diagnosed, treated for, advised to have treatment for, been prescribed or taken medication for any of the following:

   a. Alzheimer's disease, dementia, recurrent memory loss, Organic Brain Syndrome (OBS), mental incapacity or retardation? ❒ Yes ❒ No
   b. Stroke, Parkinson's disease, paralysis, paraplegia, or quadriplegia? ❒ Yes ❒ No
   c. Multiple Sclerosis, Muscular Dystrophy, Lou Gehrig's disease (ALS), Cystic Fibrosis, or Huntington's disease? ❒ Yes ❒ No

5. Have you ever been medically diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS), or have you ever tested positive for the Human Immunodeficiency Virus (HIV)? ❒ Yes ❒ No

6. In the last three (3) years have you applied for any long term care policy or long term care rider that was declined or postponed?

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7. In the last 6 months, have you been medically diagnosed as having had a heart attack or aneurysm, had angioplasty, coronary bypass surgery, vascular surgery, or heart valve replacement? ❒ Yes ❒ No

8. In the last 12 months have you:
   a. Been medically diagnosed as having or been treated for congestive heart failure or cardiomyopathy? ❒ Yes ❒ No
   b. Had a seizure of convulsion, multiple falls, or any fall resulting in a fracture? ❒ Yes ❒ No
   c. Been hospitalized overnight two (2) or more times? ❒ Yes ❒ No

9. In the last two (2) years have you been:
   a. Medically diagnosed or received treatment for leukemia, Hodgkin's' disease or other lymphoma, cancer of the bone, breast, colon, esophagus, liver, lung, ovary, pancreas stomach, uterus, or any metastatic cancer? ❒ Yes ❒ No
   b. Medically advised to have treatment or been treated for alcohol or drug use or dependency? ❒ Yes ❒ No
   c. Hospitalized for depression, bi-polar disorder or any other psychiatric disorder? ❒ Yes ❒ No

10. Have you ever been medically diagnosed, treated for, advised to have treatment for, been prescribed or taken medication for:
   a. Cirrhosis of the liver? ❒ Yes ❒ No
   b. Transient Ischemic Attack (TIA) within the last year, multiple TIA's, or a TIA with a history of heart disease? ❒ Yes ❒ No
   c. Bi-polar disorder, schizophrenia or other psychosis? ❒ Yes ❒ No
   d. Chronic kidney failure? ❒ Yes ❒ No
   e. Diabetes with a history of TIA, heart disease, or carotid artery disease? ❒ Yes ❒ No
   f. Diabetes currently treated with insulin? ❒ Yes ❒ No
   g. Rheumatoid arthritis with joint deformity, joint replacement or requiring daily use of narcotic medication? ❒ Yes ❒ No
   h. Organ transplant other than cornea? ❒ Yes ❒ No
   i. Multiple myeloma, scleroderma, myasthenia gravis, or systemic lupus? ❒ Yes ❒ No
   j. Amputation due to disease? ❒ Yes ❒ No

   If "*yes*" to any of the above questions, please list all medications in Additional Information below.

11. Have you been medically advised to have any surgery, organ transplant, diagnostic test, or medical evaluation that has not yet been completed? ❒ Yes ❒ No

ADDITIONAL INFORMATION

Proposed Insured Statement and Representations

I agree that no insurance shall be in effect until: (a) a contract has been issued and (b) the premium is paid while my insurability as stated in this application remains unchanged.

I agree that the answers set forth on this Application are true and complete to the best of my knowledge and belief, and my answers are the basis of any insurance issued. All statements made by me shall be deemed to be representations and not warranties.

I agree that this Application will be part of the policy for which I apply and that I will notify the Insurer if any statements or answers given in the Application change prior to delivery of the policy.

I agree that a verbal confirmation may be requested for this Application during a telephone interview, and that my verbal confirmation is as valid as my written signature.

CAUTION: If your answers on this Application are incorrect or untrue, Forethought Life Insurance Company has the right to deny benefits or rescind the contract.

_____ _____

Signature of Proposed Insured **Date**

_____ _____

Printed Name of Proposed Insured **Signature of Licensed Agent**

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SERFF Tracking Number:	*FRTH-128184470*	*State:*	*Arkansas*
Filing Company:	*Forethought Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*LTC3001-02*		
TOI:	*A02I Individual Annuities- Deferred Non-Variable*	*Sub-TOI:*	*A02I.003 Single Premium*
Product Name:	*Single Premium Deferred Annuity Application*		
Project Name/Number:	*Single Premium Deferred Annuity Application/LTC3001-02, LTC3002-02*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
Readability Certification - LTC3001-02 & LTC3002-02 3_22_12.pdf

Item Status: **Status Date:**

Satisfied - Item: Application
Comments:
The application being filed for approval is in the form schedule tab.

Item Status: **Status Date:**

Bypassed - Item: Life & Annuity - Acturial Memo
Bypass Reason: n/a
Comments:

Item Status: **Status Date:**

Satisfied - Item: Red-Line Versions - LTC3001 & LTC3002
Comments:
Attachments:
LTC3001-02 Fore Care Application RED-LINE VERSION.pdf
LTC3002-02 Medical Ques RED-LINE VERSION.pdf

CERTIFICATION OF READABILITY

FORM #	FORM NAME	FLESCH SCORE
LTC3001-02	FORECARE ANNUITY APPLICATION	52.0
LTC3002-02	PART 2 – MEDICAL QUESTIONNAIRE	53.0

Forethought Life Insurance Company hereby certifies that these forms achieve the Flesch reading ease scores listed.

David K. Mullen, Sr. Vice President

March 22, 2012

FORE THOUGHT

ForeCare℠ Annuity Application

☑ 9 Year

Forethought Life Insurance Company
One Forethought Center
P.O. Box 246
Batesville, IN 47006-0246
(855) 244-4441
Fax (855) 596-5404

OWNER (All Policyholder correspondence will be sent to this address.)
Name: _____ Sex: ___ Age: ___ DOB: _____
Address: _____ SSN: _____
_____ Mailing: _____
Daytime Phone: (___) _____

JOINT OWNER (Optional)
Name: _____ Sex: ___ Age: ___ DOB: _____
Address: _____ SSN: _____
_____ Mailing: _____
Daytime Phone: (___) _____

ANNUITANT (Complete only if the Owner and Annuitant are different)
Name: _____ Sex: ____ Age: ___ SSN: _____
Address: _____ Daytime Phone_____ DOB: _____
_____ Relationship to Owner: _____

JOINT ANNUITANT
Name: _____ Sex: ____ Age: ___ SSN: _____
Address: _____ Daytime Phone_____ DOB: _____
_____ Relationship to Owner: _____

PROPOSED INSURED INFORMATION (Must be Owner or Spouse, unless Trust, then must be Annuitant or Spouse)
Name: _____ Sex: ____ Age: ___ SSN: _____
Address: _____ Daytime Phone_____ DOB: _____
_____ Relationship to Owner: _____

PROPOSED JOINT INSURED INFORMATION (Optional, must be Spouse of Insured)
Name: _____ Sex: ____ Age: ___ SSN: _____
Address: _____ Daytime Phone_____ DOB: _____
_____ Relationship to Owner: _____

BENEFICIARY INFORMATION
Primary Beneficiary Name: _____ Relationship: _____ SSN: _____ %_____

Contingent Beneficiary Name: _____ Relationship: _____ SSN: _____ %_____

COUPLES DISCOUNT
Does the Proposed Insured's spouse have long term care benefits inforce or applied for with Forethought Life Insurance Company?
❑ Yes ❑ No If "yes," enter spouse information:

_____	_____	_____	_____
Spouse's Name	Date of Birth	Policy/Contract #	Social Security Number

ANNUITY DEPOSIT
❑ Annuity Deposit ..... $_____ **Type of Annuity:** ☑ **Non-Qualified**
❑ Estimated Annuity Deposit of 1035 Exchange/Transfer $_____ **Guaranteed Rate Period**: ❑ 1 Year

Free Withdrawal Option
☑ **10% Free Withdrawal** ☑ **Market Value Adjustment**

RIDER BENEFIT INFORMATION
Rider Selections: ☒ **Rider for Long-Term Care Benefits**
Optional Inflation Protection Benefit Rider (select one)
❑ I reject the 5% compounding Inflation Protection Benefit Rider

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❑ I choose the 5% compounding Inflation Protection Benefit Rider

RIDER BENEFIT INFORMATION CONTINUED

Optional Nonforfeiture Rider (select one)

❑ No I reject the Nonforfeiture Benefit Rider

❑ Yes I accept the Nonforfeiture Benefit Rider

PROTECTION AGAINST UNINTENTIONAL TERMINATION OR REDUCTION OF LONG-TERM CARE BENEFITS

This section is to be completed by the Owner. You have the right to designate a Third Party to receive notice from us of a request from you that results in reduction or termination of the Long Term Care Benefit.

I understand that I have the right to designate others to receive notice from the Company of a request from me that results in the reduction or termination of long-term care benefits.

❑ I elect **NOT** to designate another person to receive such notice.

❑ I designate the following person or entity to receive such notice.

Full Name: _____

Address: _____

City, State, Zip: _____

Telephone Number: _____

OTHER COVERAGE AND REPLACEMENT INFORMATION

The Producer shall comply with any additional state and/or company replacement requirements.

1. Does the proposed Insured currently have a long-term care policy or certificate in force (including health care service contracts or health maintenance organization contracts)? ❑ Yes ❑ No
   If "yes," provide details on Addendum.
2. Has the proposed Insured had a long-term care policy or certificate in force during the last 12 months?
   If "yes," provide details on Addendum. ❑ Yes ❑ No
3. Does the proposed Insured intend to replace any long-term care, medical or health insurance coverage with this coverage? **If "yes," provide details on Addendum.** ❑ Yes ❑ No
4. Producer must list all health insurance, including long-term care policies that he or she sold to the proposed Insured which are still in force; or were purchased in the last five years but are no longer in force. If "None," check the 'None' box. ❑ None
   Provide details on Addendum.
5. Is the proposed Insured currently eligible for benefits under or covered by Medicaid (not Medicare)? ❑ Yes ❑ No

SIGNATURES Checks must be made payable to: ***Forethought Life Insurance Company***

Do you have any existing life insurance policies or annuity contracts? ❑Yes ❑ No

Will this annuity replace, discontinue or change any existing life insurance or annuity contract issued by a company? ❑Yes ❑ No

I understand this annuity is not federally insured. I have read and understand the important disclosures located in this application. I represent that all statements and answers in this application are complete and true, on my behalf and any person who may claim any interest under this policy.

X _____ Owner's Signature

X _____ Joint Owner's Signature (if applicable)

X _____ Annuitant's Signature (if not the Owner)

X _____ Joint Annuitant's Signature (if applicable)

X _____ Insured's Signature (if not the Owner or Annuitant)

X _____ Joint Insured's Signature (if applicable)

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Signed at (~~city~~/state): _____ on (date): _____

AGENT INFORMATION

To the best of my knowledge, the applicant has an existing life insurance policy or annuity contract.

❑Yes ❑ No

Do you have any reason to believe this annuity will replace, discontinue or change any existing life insurance or annuity?

❑Yes ❑ No

As agent, have you complied with all State Replacement Regulations and completed all required State Replacement forms?

❑Yes ❑ No

Did you observe the proposed Insured having any physical or mental impairment with regard to walking or talking?

❑Yes ❑ No

If **yes**, attach documentation.

By signing this form, I certify that I have truly and accurately recorded herein the information provided by the applicant.

_____ _____

Licensed Agent's Signature | Business Name and Branch Number

_____ _____

Licensed Agent (Print Name) | State License Number or Agent Number

STATE REQUIRED NOTICES

AR, HI, KY, MA, ND, OK, PA, SD, TN, and WA Residents

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, submits an application for insurance containing any materially false, incomplete, or misleading information, or conceals for the purpose of misleading, any material fact, is guilty of insurance fraud, which is a crime and in certain states, a felony. Penalties may include imprisonment, fine, denial of benefits, or civil damages.

CA Residents – Reg. 789.8

The sale or liquidation of any asset in order to buy insurance, either life insurance or an annuity contract, may have tax consequences. Terminating any life insurance policy or annuity contract may have early withdrawal penalties or other costs or penalties, as well as tax consequences. You may wish to consult independent legal or financial advice before the sale or liquidation of any asset and before the purchase of any life insurance or annuity contract.

CO Residents

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of any insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Department of Regulatory Agencies.

ME Residents

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MD, NM and RI Residents

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NJ Residents

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

VA Residents

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

FORE THOUGHT®

ForeCare℠ Annuity Application – Medical Questionnaire~~Part 2~~

Forethought Life Insurance Company
One Forethought Center
P.O. Box 246
Batesville, IN 47006-0246
855-244-4441

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To begin interview fax this form and HIPAA to 855-206-8731 and call 877-272-0578.

Forethought Annuity ~~LTC~~ Application – ~~Part 2~~ Medical Questionnaire

Proposed Insured

Name (First, Middle Initial, Last)		Date of birth (mm/dd/yyyy)	
Mailing Address		Height	Weight
City	State	Social Security Number	

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Proposed Insured Health Questions (Any questions 10=-6 answered 'Yes' will be an automatic decline)

1. Are you currently confined to a nursing facility, receiving home health care, using Adult Day Care services, receiving hospice care, residing in an Assisted Living Facility, or in the last 12 months have you used or been medically advised to seek such confinement or care, or are you currently hospitalized or confined to a bed?
   ❑ Yes ❑ No
2. Do you require assistance or supervision in performing any of the following activities: taking medications, bathing, dressing, transferring, eating, toileting, bowel or bladder control or, mobility., or taking medications?
   ❑ Yes ❑ No
3. Do you use or have you been medically advised to use a walker, multi prong cane, wheelchair, motorized scooter, hospital bed, stair lift, or any medical appliance such as oxygen, respirator, dialysis machine or have a defibrillator implanted?
   ❑ Yes ❑ No
4. Have you been medically diagnosed, treated for, advised to have treatment for, been prescribed or taken medication for any of the following:
   a. Alzheimer's disease, dementia, recurrent memory loss, Organic Brain Syndrome (OBS), mental incapacity or retardation? ❑ Yes ❑ No
   b. Stroke, Parkinson's disease, paralysis, paraplegia, or quadriplegia? ❑ Yes ❑ No
   c. Multiple Sclerosis, Muscular Dystrophy, Lou Gehrig's disease (ALS), Cystic Fibrosis, or Huntington's disease? ❑ Yes ❑ No

~~If "*yes*" to any of the above questions, please list all medications in #12 - Additional Information.~~

5. Have you ever been medically diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS), or have you ever tested positive for the Human Immunodeficiency Virus (HIV)?
   ❑ Yes ❑ No
6. In the last three (3) years have you applied for any long term care policy or long term care rider that was declined or postponed?
   ❑ Yes ❑ No
7. In the last 6 months, have you been medically diagnosed as having had a heart attack or aneurysm, had angioplasty, coronary bypass surgery, vascular surgery, or heart valve replacement?
   ❑ Yes ❑ No
8. In the last 12 months have you:
   a. Been medically diagnosed as having or been treated for congestive heart failure or cardiomyopathy? ❑ Yes ❑ No
   b. Had a seizure or convulsion, multiple falls, or any fall resulting in a fracture? ❑ Yes ❑ No
   c. Been hospitalized overnight two (2) or more times? ❑ Yes ❑ No
9. In the last two (2) years have you been:
   a. Medically diagnosed or received treatment for leukemia, Hodgkin's' disease or other lymphoma, cancer of the bone, breast, colon, esophagus, liver, lung, ovary, pancreas, stomach, uterus, or any metastatic cancer?
   ❑ Yes ❑ No

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b. Medically advised to have treatment or been treated for alcohol or drug use or dependency? ❑ Yes ❑ No
c. Hospitalized for depression, bi-polar disorder or any other psychiatric disorder? ❑ Yes ❑ No

10. Have you ever been medically diagnosed, treated for, advised to have treatment for, been prescribed or taken medication for:

a. Cirrhosis of the liver? ❑ Yes ❑ No
b. Transient Ischemic Attack (TIA) within the last year, multiple TIA's, or a TIA with a history of heart disease? ❑ Yes ❑ No
c. Bi-polar disorder, schizophrenia or other psychosis? ❑ Yes ❑ No
d. Chronic kidney failure? ❑ Yes ❑ No
e. Diabetes with a history of TIA, heart disease, or carotid artery disease? ❑ Yes ❑ No
f. Diabetes currently treated with insulin? ❑ Yes ❑ No
g. Rheumatoid arthritis with joint deformity, joint replacement or requiring daily use of narcotic medication? ❑ Yes ❑ No
h. Organ transplant other than cornea? ❑ Yes ❑ No
i. Multiple myeloma, scleroderma, myasthenia gravis, or systemic lupus? ❑ Yes ❑ No
j. Amputation due to disease? ❑ Yes ❑ No

If "*yes*" to any of the above questions, please list all medications in #12 - Additional Information.

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11. Have you been medically advised to have any surgery, organ transplant, diagnostic test, or medical evaluation that has not yet been completed? ❑ Yes ❑ No

12. **ADDITIONAL INFORMATION**

Proposed Insured Statement and Representations

I agree that no insurance shall be in effect until: (a) a contract has been issued and (b) the premium is paid while my insurability as stated in this application remains unchanged.

I agree that the answers set forth on this Application are true and complete to the best of my knowledge and belief, and my answers are the basis of any insurance issued. All statements made by me shall be deemed to be representations and not warranties.

I agree that this Application will be part of the policy for which I apply and that I will notify the Insurer if any statements or answers given in the Application change prior to delivery of the policy.

I agree that a verbal confirmation may be requested for this Application during a telephone interview, and that my verbal confirmation is as valid as my written signature.

CAUTION: If your answers on this Application are incorrect or untrue, Forethought Life Insurance Company has the right to deny benefits or rescind the contract.

_____ _____
Signature of Proposed Insured **Date**

_____ _____
Printed Name of Proposed Insured **Signature of ~~Examiner~~Licensed Agent**